MTS, Inc.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Received 1/13/07

PRINTED: 10/30/2007 FORM APPROVED OMB NO. 0938-0391

TATEMENT ND PLAN O	OF DEFICIENCIES F CORRECTION	(:(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION 3		(3) DATE SURVEY COMPLETED	
		09G183	B. WING			10/18/2007		
NAME OF PI	ROVIDER OR SUPPLIER		:	44	EET ADDRESS, CITY, STATE, ZIP CODE 114-16 JAY STREET, NE /ASHINGTON, DC 20019			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y NUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S FLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCIED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
W 000	INITIAL COMMEN	rs	W	000				
N/ 470	October 16, 2007 to survey was initiated A random sample of from a resident popone male with various added for a for The findings of the observations, internand at two day proceed and administ incident reports.	vey was conducted from hru October 18, 2007. The dusing the full survey process of three clients was selected bulation of four females and bus disabilities. A fourth client custed review in healthcare, survey were based on views with staff in the home grams, as well as a review of rative records, including	w	120				
W 126	OUTSIDE SOURC	ES scure that outside services	**	120				
	Based on observation record review, the monitor each client the needs were me	is not met as evidenced by: ion:, staff interview, and faci ity failed to effectively is day program to assure that et for two of three clients uple. (Client #2 and #3)	٠			,		
	received the appro- equipment during as evidence below 1. Observations of 10/16/07 at appro- Client #2 was serv with double portion Further observation	o ensure that Client #2 and #3 priate adaptive feeding functions at the day program onducted during funch time on kimately 12:26 PM revealed that and her prescribed pureed diet as in a round built-up plate.			W120 1. MTS will purchase the needed for client #2 and provide them day program by 11-15-07. The at least the second set given to program. The QMRP will visi program at minimum monthly that the program has and uses adaptive feeding equipment sufor client #2 routinely.	to the is will be the the the to ensure the		
ABORATOR	DIRECTORS ON PROV	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		Resident Dade	Ares	(X6) DATE	

Any deficiency statement ending with an a sterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ollowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 tays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		(X3) DATE SURVEY COMPLETED	
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	09@183	B. WING		10/1	8/2007
ROVIDER OR SUPPLIER	·	44	114-16 JAY STREET, NE		
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INITIAL COMMEN	TS	W 000			
October 16, 2007 is survey was initiated A random sample from a resident polone male with various added for a form the findings of the observations, internand at two day proclient and administracident reports. 483.410(d)(3) SEROUTSIDE SOURCE.	thru October 18, 2007. The dusing the full survey process, of three clients was selected pulation of four females and bus disabilities. A fourth client cused review in healthcare, survey were based on views with staff in the home grains, as well as a review of trative records, including CVICES PROVIDED WITH CES	, W 120			
Based on observarecord review, the monitor each clien the needs were modeled in the sar. The findings included in the facility failed to received the appropriate equipment during as evidence below. 1. Observations of 10/16/07 at approximate the control of the	tions, staff interview, and facility failed to effectively it's day program to assure that et for two of three clients inple. (Client #2 and #3) le: Densure that Client #2 and #3 ipriate adaptive feeding funch time at the day program it conducted during lunch time on climately 12:26 PM revealed that ed her prescribed pureed diet in a round built-up plate.		for client #2 and provide then day program by 11-15-07. The at least the second set given to program. The QMRP will visit program at minimum monthly that the program has and uses	to the is will be the it the i	
	SUMMARY ST. (FACH DEFICIENC REGULATORY OR I INITIAL COMMEN A recertification sur October 16, 2007 is survey was initiate A random sample from a resident por one male with varions and at two day pro- client and administ incident reports, 483,410(d)(3) SEF OUTSIDE SOURC The facility must as meet the needs of This STANDARD Based on observations of the included in the same the needs were me included in the same the needs of The facility failed to received the approximate of the properties of the p	SUMMARY STATEMENT OF DEFICIENCIES (PACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS A recertification survey was conducted from October 16, 2007 thru October 18, 2007. The survey was initiated using the full survey process. A random sample of three clients was selected from a resident population of four females and one male with various disabilities. A fourth client was added for a focused review in healthcare. The findings of the survey were based on observations, interviews with staff in the home and at two day programs, as well as a review of client and administrative records, including incident reports. 483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observations, staff interview, and record review, the facility failed to effectively monitor each client's day program to assure that the needs were met for two of three clients included in the sample. (Client #2 and #3) The findings include: The facility failed to ensure that Client #2 and #3 received the appropriate adaptive feeding equipment during lunch time at the day program as evidence below: 1. Observations conducted during lunch time on 10/16/07 at approximately 12:26 PM revealed that Client #2 was served her prescribed pureed diet with double portions in a round built-up plate. Further observations revealed that the client used	ROVIDER ON SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (FACH DEFICIENCY ON LIST REPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A recertification survey was conducted from October 16, 2007 thru October 18, 2007. The survey was initiated using the full survey process. A random sample of three clients was selected from a resident population of four females and one male with various disabilities. A fourth client was added for a focused review in healthcare. The findings of the survey were based on observations, interviews will staff in the home and at two day programs, as well as a review of client and administrative records, including incident reports. 483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. 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ROVIDER ON SUPPLIER ROVIDERS PLAN OF CORRECT ON SUPPLIER ON SUPPLIER ON SUPPLIER ON SUPPLIER OF CORRECT ON SUPPLIER ON SUP	ROYNDER ON SUPPLIER O9G183 STREET ADDRESS, CITY, STATE, ZIP CODE 41416 LAY STREET, NE WASHINGTON, DC 20019 PROVIDERS PLAN OF CORRECTION (FACH) DEFICIENCY MUST REPRECEDED BY SUL REGULAL ONY OR LSC DENTIFYING INFORMATION) INITIAL COMMENTS A recertification survey was conducted from Octuber 16, 2007 thru October 18, 2007. The SUNWAY was initiated using the full survey process. A random sample of three cellents was selected from a resident population of four females and one male with various disabilities. A fourth client was added for a focused review in healthcare. The findings of the survey were based on observations, interviews will staff in the home and at two day programs, as well as a review of client and administrative records, including incident reports. 483.410(b)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observations, staff interview, and record review, the facility failed to effectively monitor each client's day program to assure that the needs were met for two of three clients's included in the sample. (Client #2 and #3 received the appropriate adaptive feeding equipment during lunch time at the day program as evidence below: 1. Observations conducted during lunch time on 10/16/07 at approximately 12-26 PM revealed that Client #2 was served her prescribed pureced diet with double portions in a round built-up plate. Further observations revealed that the client used

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients, (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is regulate to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDENSUPPLIENCLIA IDENTIFICATION NUMBER:	(X2) MULTIP A BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		u9G183	8. WING		10/1	8/2007
NAME OF P	ROVIDER OR SUPPLIER		\ 44	EET ADDRESS, CITY, STATE, ZIP (14-16 JAY STREET, NE ASHINGTON, DC 20019		mq
(X4) ID PREFIX TAG	JEACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (BACH CORRECTIVE ACTIV CROSS-RÉFÉRENCED TO TH DEFICIENCY	ON SHOULD RF HE APPROPRIATE	(X5) COMPLETION DATE
W 120	a coated tablespoor earlier interview wapproximately 11:: Client #2 feeds he coated tablespoor Further interview was revealed that Client diet with double portion of the coated tablespoor 10/17/07 at approximately 10/17/07 at approximately 10/17/07 at approximately 10/16/07 at	on to consume her moal. It the day program at 25 AM, it was revealed that reelf independently using a land Dycem mat as needed with the day program staff of #2 was prescribed a purportions. Review of the Plan (ISP) dated 6/25/07 eximately 12:00 PM revealed the equipment included a broadlime. Review of the rapist Assessment Addend mended that Client #2 contional divided plate to increase the ISP/OT in the day proceed a prescribed regular generations revealed that the eximately 11:40 PM revealed that the eximately 11:40 PM revealed that the open a blue mug with a small pendently. In an earlier at approximately 10:47 AI to Client #3 likes the blue means the ISP/OT in the day program's Adult at approximately 10:47 AI to Client #3 likes the blue means the liquids independently endum dated 1/10/07 on eximately 2:47 PM that Client #3 could benefit the mat, right handed curves the country of the count	et a ed ed ed ed ed that uilf-up onder dum ould ease up ed that ground e that ground e hall en ed that ground e hall en ed the hall en ed the y.)	2. Both the day program a use a cup with straw as for #3. The day progra with straw now. The h to cup with straw by 1 staff will be trained on method for Client # 3 h	the best option m uses the cup ome will switch 1/15/07. The cup/straw	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	TALEMENT OF DEFICIENCIES (X1) PROVIDENCIUP LIERVELIA NO PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		09G183	B. WII	IG		10/18	3/2007
M T S	ROVIDER OR SUPPLIER			44	PET ADDRESS, CITY, STATE, ZIP CODE 114-16 JAY STREET, NE VASHINGTON, DC 20019	,	
(X4) IÜ PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL I SC IDENTIFYING INFORMATION)	ID PREF TAG		PHOVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REPERENCED TO THE APPI DEFICIENCY)	DULD BE	(XS) COMPLETION DATE
W 120	Continued From page spoon, and nosev	age 2 cup to increase drinking	W	120			
	efficiency. Intervie at 3:00 PM reveale straw used at the recommended nos purpose; however use one cup consi	ew with the OT on the same day and that "the blue mug with the day program and say cup serves the same, we need to narrow it down and stently".	١٨/	124		·	
W 124	483.420(a)(2) PR0 RIGHTS 	OTECTION OF CLIENTS	VV	1,24			:
	Therefore the facil parent (if the clien of the client's med and behavioral st	ensure the rights of all clients. Ity must inform each client, It is a minor), or legal guardian, Itical condition, developmental atus, attendant risks of the right to refuse troatment.			,		
	Based on observative rification, the fall each client or their of the client's med and behavioral statement, and the	is not met as evidenced by: ation, Interview and record cility failed to ensure the right of r legal guardian to be informed tical condition, developmental atus, attendant risks of e right to refuse treatment for in the sample. (Client #2 and	í				
	The findings inclu	de:					
	administration on approximately 7:5 received Fluoxetii Hydrochloride 50 Interview with the 2007 at approxim	the morning medication October 16, 2007 at 5 AM, revealed Client #2 ne HCL 40 mg and Naltrexone mg (1/2/ tab BID) by mouth. nursing staff on October 16, ately 7:58 AM revealed that the prescribed for behavior			W124 Client # 2's mother has agreed to consent and has been given the a paperwork to do so, and provide the BSP and drug regimen. The cobtain the signed documents by	ppropriate consent for QMRP will	

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DÉPARTMENT OF LIEALTH AND HUMAN SÉRVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		09G183	a. Wi	√G		10/	18/2007
NAME OF F	PROVIDER OR SUPPLIER			441	ET ADDRESS, CITY, STATE, ZIP CODE 4-16 JAY STREET, NE ASHINGTON, DC 20019		
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W 124	orders dated Octot at approximately 1 Fluoxetine HCL 40 and Naltrexone Hymouth twice a day Support Plan (BSP address behaviors mouthing and finge dropping/banging. Mental Retardation October 16, 2007 a revealed that Clien guardian. Further #3's mother signs procedures, howeviegal guardian. The roview of Clier Assessment dated 2007 at approxima the client was not clindependent decision day program platinancial affairs. The evidence that the filegally authorized mother than the filegally authorized of the health bornef associated with the medications and conditionally, the fair that substituted colar legally recognize. 2. Observation of the administration on Capproximately 7:45 received Risperdal	priew of the client's physicians of the client's physicians of 2007 on October 16 2007 of 10 AM revealed that mg by mouth every morning drochloride 50 mg (1/2/ tab) by was incorporated in a Behavior) dated June 13, 2007, to associated with hand er sucking, and head Interview with the Qualified Professional (QMRP) on at approximately 10:15 AM the 2 did not have a legal interview revealed that Client the consents for her medical fer she was not the client's of the 2's Psychological June 13, 2007 on October 17, tely 12:00 PM indicated that competent to make ons concerning her residential dements, treatment plan or ere was no documented ecility informed Client #2 or a epresentative, as appropriate, its and risks of treatment use of her psychotropic	W	124			

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PRINTED: 10/30/2007

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY STATEMENT OF DEPICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A, BUILDING B. WING 09G183 10/18/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4414-16 JAY STREET, NE MT5 WASHINGTON, DC 20019 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY W 124 W 124 Continued From page 4 October 16, 2007 at approximately 7:50 AM Client #3's sister has already signed consent revealed that the medications were prescribed for forms and forms establishing her as the behavior management. Review of the client's primary decision-making support person. physicians orders dated September 28, 2007 on 11-1-07. (see Attached copies). October 16, 2007 at approximately 10:00 AM Both relatives will be contacted and revealed that Risperdal 1 mg by mouth twice a informed consistently on consent issues and day and Clonazepain 0.5 mg by mouth twice a prior consent will be obtained for each for day was incorporated in a Behavior Support Plan (BSP) dated July 1, 2007, to address behaviors all necessary issues. associated with physical aggression (i.e. hitting, kicking or graphing others) and non-compliance, Interview with the Qualified Mental Retardation Professional (QMRP) on October 16, 2007 at approximately 10:15 AM revealed that Client #3 did not have a legal guardian. Further interview revealed that Client #3's sister signs the consents for his medical procedures, however she was not the client's legal guardian. The review of Client #3's Psychological Assessment dated July 1, 2007, on October 16, 2007 at approximately 10:45 AM indicated that the client was not competent to make independent or informed decisions concerning medical and psychological treatment. There was no documented evidence that the facility informed Client #3 or a legally authorized representative. as appropriate, of the health benefits and risks of treatment associated with the use of his psychotropic medications and corresponding BSP. Additionally, the facility failed to provide evidence that substituted consent had been obtained from a legally recognized individual or W 153 W 153 483.420(d)(2) STAFF TREATMENT OF CLIENTS

The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as

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STATEMENT OF OBFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		09G183	B. WING		10/1	8/2007	
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP (4414-16 JAY STREET, NE WASHINGTON, DC 20019	conf		
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W 153	Injuries of unknown immediately to the officials in accordatestablished procedurestablished procedurestablished procedurestablished procedurestablished procedurestablished procedurestable of interview incidents that pose to governmental agregulation (22 DCM 3519.10). The findings includes the findings includes the findings includes the findings includes the finding in her wheelchair are review of the incident her wheelchair are review of the inc	is source, are reported administrator or to other noce with State law through luros. is not met as evidenced by: and record review, report a risk to client health or safety gencies, as required by DC MR Chapter 35 Section	W 153	W153 1. The day program involve routinely send incident to rany other residential say their obligation is to reports to the DDS case will meet with the day pensure that the program such incident reports to within 24 hours, so that submitted to DOH and that they send them to Din addition to DDS case will involve DDS case remains an agreement is to the submitted and submitted an agreement is to the submitted and submitted an agreement is to the submitted and submitte	reports to MTS providers, They be send such manager. MTS program to agrees to send the MTS home it can be filed by MTS or OOH and MTS manager. MTS manager to		
	2. Review of an un February 5, 2007 of approximately 9:05 was transported to for vomiting coffee subsequently admi bleeding. There was incident was report 12, 2007.	mental agencies as required. usual incident report dated on October 16, 2007 at is AM revealed that Client #1 the hospital emergency room ground material and was atted for gastric intestinal as no evidence that this ted to the DOH until February usual incident report dated		2. The facility failed to ser report for client #1 to the timely manner in this can will retrain all staff to extend the sent to the IMC by the shift on which the incident of the sent to the IMC by the shift on which the incident of the sent to the IMC by the shift on which the incident of the sent to the IMC by the shift on which the incident of the sent to the IMC by the shift on which the incident of the sent to the IMC by the shift on which the incident of the sent to the sent	ne IMC in a lase. The QMRP insure that each int reports must be end of the lent occurs.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		09G183	B. WING		10/1	8/2007
NAME OF P	RÓYIDER OR SUPPLIER		44	EET ADDRESS, CITY, STATE, ZIP COD! M4-16 JAY STREET, NE MASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREHX TAG	PROVIDER'S PLAN OF CORK (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
W 153	approximately 9:15 was transported to for evaluation of a side of his neck. The incident was report 4, 2007.	ige 6 on October 16, 2007 at AM revealed that Client #3 the hospital emergency room superficial burn on the right nere was no evidence that this ed to the DOH until February	W 153			
VV 154	The facility must he violations are thoroward this STANDARD Based on Interview the facility failed to thorough investigal	ave evidence that all alleged	W 104	W154 The incident investigation was a by the home's QMRP at that fin not properly signed off. The Res Director will review all such included they are full and complete, including properly signed off.	ne but was sidential eidents in the to ensure	
W 159	February 28, 2007 approximately 9:15 was transported to for evaluation of a side of his neck of record review on Capproximately 9:25 investigative report was no documente investigation was 0 483.430(a) QUALITIES RETARDATION Programment of the stransport of the str	usual incident report dated on October 16, 2007 at AM revealed that Client #3 the hospital emergency room superficial burn on the right unknown origin. Interview and october 16, 2007 at AM revealed an undated on Client #3's injury. There are evidence when this conducted by the facility.	W 159			
		ated and monitored by a	· 			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/30/200/ FORM APPROVED OMB NO. 0938-0391

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TATEMENT ND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDEN/SUPPLIER/GLIA IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		09G183	B. WII	VG		10/18	/2007
NAME OF P	ROVIDER OR SUPPLIER			44	ET ADDRESS, CITY, STATE, ZIP CODE 14-16 JAY STREET, NE ASHINGTON, DC 20019		
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W 159	Continued From page 7 qualified mental retardation professional.		W	159		,	
	Based on observative review, the facility	is not met as evidenced by: Ition, staff interview and record 's Qualified Mental Retardation RP) failed to integrate, onitor its clients active treatment					
l	The findings include						
	ensure that Client	W120. The QMRP failed to tale the two two two two treeding equipment during day program.			W159 1. See W120		
	ensure that failed	W189. The QMRP failed to I to ensure that each employee ed with adequate training that loyees to perform his or her			2. See W189		
	3. Cross refer to ensure that Clier repair.	3. Cross refer to W436. The QMRP failed to ensure that Client #1's wheelchair was in good			3. See W436 4. See W436		
	Cross refer to ensure that clien adaptive equipm	W436. The QMRP failed to ts were provided with necessary ent.			366 11730		
	inform the Interd	W220. The QMRP failed to lisciplinary Team (IDT) to ensure id a speech/language recommended by the incident portinator.			5. See W220		
	6. The QMRP f	ailed to ensure that staff t #3 every half hour during the					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
•		09G183	E, WING _		10/1	8/2007
NAME OF P	ROVIDER OR SUPPLIER		4	EET ADDRESS, CITY, STATE, ZIP C 414-16 JAY STREET, NE /ASHING FON, DC 20019	ODF	
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SO IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	COMPLETION DATE
W 159	Review of an unus February 28, 2007 approximately 9:15 was transported to tor evaluation of a side of his neck of undated investigat incident revealed t Client #3's head w railing and the wall review revealed a monitor Client #3 a monitor Client #3 a to an interview with 2007 at approxima acknowledged tha documenting bed Client #3. There w	ual incident report dated on October 16, 2007 at a AM revealed that Client #3 the hospital emergency room superficial burn on the right unknown origin. Review of an ive report regarding this hat the injury occurred when as caught between the bed during the night. Further recommendation that staff every half hour during the night on the QMRP on October 17, stely 3:25 PM it was at the staff were not checks every half hour on as no documented evidence being monitored every half	W 159	6. The QMRP discussed to recommendation for clumonitor him every ½ health agreed that this wand unnecessary. They hourly checks would be appropriate and sufficient and RN will collaborate collecting data hourly staff on it's implementation.	ient #3 to our overnight, as too intrusive agreed that both more cut. The QMRP on a form for und will train	
	provided a plate ris Occupational Ther Breakfast observa approximately 6:40 placed three divide order to elevate Cl direct care staff or approximately 6:50 did not have a plat assessment dated 17, 2007 at approx Client #1 was to be modify her feeding overall independer	d to ensure that Client#1 was ser as recommended by the rapist (OT) as evidenced by: tion on October 16, 2007 at DAM, revealed that the staff of plates on top of each other in ient#1's plate. Interview with DOCTOBER 16, 2007 at DAM, revealed that Client #1 or riser. Review of the OT January 10, 2007 on October kimately 1:15 PM, revealed that of provided a plate riser to penvironment and increase note in self feeding. There was plate riser was plate riser was provided as	•	7. Client #1's plate Riser v by 11-15-07. The QMR checklist of the recommaccepted by the team for service and for each per This checklist will be us recommendations and c properly implemented.	P will develop a lendations om each clinical son supported. sed to track	

PRINTED: 10/30/2007

DEPARTMENT OF HEALTH	I AND HUMAN SERVICES		FORM APPROVED
CENTERS FOR MEDICARE	& MEDICAID SERVICES		OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED

ATE SURVEY B, WING 09G183 10/18/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4414-16 JAY STREET, NE MTS WASHINGTON, DC 20019 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES Ю (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (FACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE REGULATORY OR LEC IDENTIFYING INFORMATION) TAÇ TAG DEFICIENCY) W 159 Continued From page 9 W 159 recommended by the OT. 8. The QMRP failed to ensure that Client#1 was provided adult hobby materials as recommended by the Psychologist as evidenced by: Evening observation on October 16, 2007 at See Response for #7 above. approximately 4:45 PM, revealed that the staff In addition, the OMRP will ensure that assisted Client#1 in playing with a child age key adult hobby materials are replenished board. Review of the psychological assessment as needed. dated June 10, 2007 on October 17, 2007 at approximately 12:10PM, revealed that Client #1 was to be provided adult hobby materials that made noise. In an interview with the QMRP on October 17, 2007 at approximately 1:20 PM it was acknowledged that Client #1 did not have adult hobby materials that made noise. There was no evidence that adult hobby materials that made noise were provided as recommended by the Psychologist. [Note: The QMRP brought adult hobby materials for Client #1 on October 18, 2007] 9. The QMRP falled to ensure that Client #1 was provided prune juice and crariborry juice as The QMRP will retrain staff on recommended by the nutritionist as evidenced by:

Breakfast observation on October 16, 2007 at approximately 6:40 AM, revealed that the staff served Client #1 apple juice. Review of the Primary Care Physicians orders dated September 28, 2007 revealed that Client #1 was to have prune juice two to three times a week and cranberry juice three times a week. Environmental observation on October 17, 2007 at approximately 9:40 AM revealed that there was no prune juice and cranberry juice in the facility.

shopping according to the planned menas, 11-20-07. In addition the facility manger will check the food and drink supplies on a weekly basis (Mondays) to ensure that all items planned for all of the week's meals are in adequate supply.

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	D. 10/30/2007 A APPROVED D. 0 <u>938-0391</u>
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NIJMBER;	(X2) MU A. BUIL	ILTIPLE CONSTRUCTION DING	(X3) DATE S	SURVEY
		09G183	B. WING	<u> </u>	10/18/2007	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
MTS				4414-16 JAY STREET, NE WASHINGTON, DC 20019		
(X4) IU PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIL YING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AL DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
W 159	2007 at approximate acknowledged that juice and cranberry no evidence that provided as reconstruction of the provided as reconstruction of the provided as reconstruction of the processional program of the practices. This STANDARD is Based on staff interfacility failed to ensulicensed and/or cert District of Columbia. The finding include: The review of personal processional and processional program of the processional services.	the QMRP on October 17, ely 9:45 AM it was the facility did not have prune juice in the facility. There was une juice and cranberry juice commended by the nutritionist. Provided prune juice and Client #1 on October 18, 2007] FESSIONAL PROGRAM of staff must be licensed, ed, as applicable, to provide es by the State in which he or so not met as evidenced by: view and record review, the are that all professionals are diffied in accordance with the Laws.	W 15	59	odiatrist's ist's. Both of personnel als and has deficiency All are	
W 189	Recreational Therapavailable for review. the Podiatrist, Recrepharmacist were car with the Health Occ Title 3 Chapter 12, Slicensee shall displaany and all places of the licensee.")	enses for the Podiatrist, point and Pharmacist were not There was no evidence that eational Therapist and rrently licensed in accordance upation Revision Act (HORA), Section 3-1205.13 ("Each by the license conspicuously in f business or employment of	W 18	MTS will continue to track thes will proactively notify staff of u personnel file issues.	e often and peoming	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

		I AND HUMAN SERVICES	,			FORM	10/30/2007 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED	
		09G183	B. WII	NG		10/1:	B/2007
NAME OF P	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE	- -	
MTS				1	14-16 JAY STREET, NE ASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	(TÉMENT OF DEFICIENCIES I MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IÜ FREF TAG	'IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 189	Continued From pa	ge 11	W	189			
	initial and continuin	ovide each employee with g training that enables the m his or her duties effectively, petently.					·
	Based on observation review, the facility femployee had been training that enable	s not met as evidenced by: ion, interview, and record alled to ensure that each in provided with adequate is the employees to perform fectively, efficiently and					
	10/16/07 at approximate Client #2 eating varied with some difficulty client was further of her right hand while Qualified Mental Re(QMRP) on 10/18/0 revealed that Client while feeding. Rev Therapy (OT) Adderecommended that hand when perform time during the sun	inducted during snack time on imately 4:34 PM revealed nilla pudding independently using her right hand. The bserved to have a mitten on a feeding. Interview with the etardation Professional 27 at approximately 11:49 AM at #s mittens can be on or officew of Client #2's Occupational and the hand mitten be on the left hing self-feeding tasks. At no vey was staff observed to ditten from Client #2's right d as			W189 1. QMRP will retrain staff to ensichem #2's mitten is removed right hand during meals. The QMRP will observe at mirrone meal weekly to ensure rouncompliance.	from her	
		W460. The facility failed to defective training allergies.			2. See response for W460		

W 192 483.430(e)(2) STAFF TRAINING PROGRAM

W 192

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IULTIFL ILDING	E CONSTRUCTION	(X3) DATE S COMPL	
		09G183	B. WIN	1e —	 	10/1	18/2007
NAME OF P	PROVIDER OR SUPPLIER		•	441	ET ADDRESS, CITY, STATE, ZIP CODE 14-16 JAY STREET, NE ASHINGTON, DC 20019	 -	
(X4) IU PREF(X TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 192	Continued From pa	age 12	W 1	192			
		o work with clients, training is and competencies directed lith needs.			,		
	Based on observat review, the facility f implement emerge	is not met as evidenced by. tion, staff interview and record failed to effectively train staff to incy measures for five of five y. (Clients #1, #2, #3 and #4)					
	The findings includ	le·					
	been effectively tra measures for five of evidenced by: Interview with the F- 2007 at approximal staff was not traine October 18, 2007 a revealed that three current CPR certified documented evider CPR training and of 2. The QMRP faile been effectively trainmeasures for five of evidenced by: In an interview with	ad to ensure that all staff had ained to implement emergency of five clients in the facility as House Manager on October 18, ately 10:00 AM revealed that alled in CPR. Record review on at approximately 10:10 AM out of ten staff did not have cations. There was no note that all direct care staff had current CPR certifications. There was no note that all direct care staff had current CPR certifications. There was no note that all staff had current CPR certifications.			W192 1. All ten staff have current CPR certification and training inclusion three cited, but MTS has not y received the cards from the training was done i September 2007, MTS will obscards by 11-30-07. A signature sheet and agenda a attached as proof of the training	iding the ret dining the tain the	
	acknowledged that Aid. Record review approximately 10:1:	t all staff was not trained in First von June 25, 2007 at 15 AM revealed that three out have current First Aid			2. See response for # 1 above.		
		1		1	· ·		1

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		CONSTRUCTION	(X3) DATE S COMPLE	
		09G183	e. WIN	IC		10/1	8/2007
NAME OF P	ROVIDER OR SUPPLIER			4414-	ADDRESS, CITY, STATE, ZIP CODE 16 JAY STREET, NE HINGTON, DC 20019	,	
(X4) ID PREFIX LAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MIST REPRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		FROVIDER'S PLAN OF CORRE (EACH GORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD HE	(X5) COMPLETION DATE
W 192 W 220	evidence that all dir training and current 483.440(c)(3)(v) IN The comprehensive	ge 13 e was no documented ect care staff had First Aid First Aid certifications. DIVIDUAL PROGRAM PLAN c functional assessment must I language development.	w				
	Based on record re facility falled to ens recommended spe-	s not met as evidenced by view and staff interview, the ure the provision of a sech and language assessment ts in the sample. (Client #1		-			
	1. Breaktast observapproximately 6:40 1 was observed eat curved built-up spotentially prompted to client complied by seview of Client #1 September 28, 200 on October 17, 200 diagnosis of spastimately on October 11:50 AM revealed speech/ language awith the Qualified Merofessional (QMR 11:55 AM it was account to the december 11:50 AM revealed speech/ language awith the Qualified Merofessional (QMR 11:55 AM it was account to documente	vation on October 16, 2007 at AM, revealed that Client # ing her food with a left handed on at a fast pace. Staff he client to slow down and the slowing down her eating pace. 's physicians's orders dated 7 at approximately 11:45 AM 7 revealed that she has a c quadriplegia. Medical record 17, 2007 at approximately that Client #1 did not have a assessment. In an interview			Client #1 does have a speech assessment that was filed und Assessment that was filed un "Speech Pathology" in the IS (see attached copy)	ler speech der	

DEPARTMENT OF	HEALTH AND HU	IMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COMPLETED	
	09G183	B. WIN	IG_		10/18	/2007
NAME OF PROVIDER OR SUPPLIER M T S			44	EET ADDRESS, CITY, STATE, ZIP CODE 114-16 JAY STREET, NE VASHINGTON, DC 20019		
(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUIL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
Cotober 16, 2007 revealed that on Juntansported to the admitted for right I discharged on Juntansported a recomme evaluated by the rule out dysphasia food, thin liquids a the OMRP on Octacknowledged that speech/language was no document been assessed by therapist. W 231 1 W 231	adated investigative report on at approximately 9:25 AM une 1, 2007, Client # 4 was hospital emergency room and ower lobe pneumonia and at 4, 2007. Further review mendation for Client # 4 to be speech/ language therapist to and associated aspiration of and salvia. In an interview with ober 17, 2007 at 3:55 PM It was at Client #4 did not have a assessment completed. There ed evidence that the client had a the speech/ language NDIVIDUAL PROGRAM PLAN the individual program planted in behavioral terms that ble indices of performance. is not met as evidenced by: we and record review the facility hat all client program objectives to provide measurable indices of wo of four clients in the sample. orde: at #1's Individual Program Planter 2007, on October 17, 2007 1:50 PM included the following tent objective:		231	swallowing study done on 11-Client #1 is also scheduled for swallow study on 11-09-07. T dysphasia issue will be addres that time.	that the seed at t	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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MTS	ROVIDER OR SUPPLIER		44	EET ADDRESS, CITY, STATE, ZIP CODE 414-16 JAY STREET, NE (ASHINGTON, DC 20013	:	
(X4) ID PRFFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S I*LAN OF CORR (EACH CORRECTIVE ACTION & CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
W 231	c. Pay for item e. Wait for the cha f. Say thank you Further review of staff was instructed accomplished if a and (-) if all five or refused. In an interpretation Profector acknowledged that criteria for master There was no evicariteria provided in performance at each of the complete of the complete of the complete of the complete of the chapter of	ange/receipt the objectives indicated that the ed to document a (+) for all five objectives were completed bjectives were not met or erview with the Qualified Mental saional (QMRP) on October 18, ately 2:00 PM it was at the program had multiple y and was not measurable. If the measurable indices of each level. In #3's Individual Program Plan D, on October 18, 2007 at 6 AM included the following ent objective:	W 231	The then aims to measure her level of participation and coorperation. Sinstructed to score plus(+) if she -Accepts assistance -Follows instructions -coorperates/participates fully. For each step and minus (-) if she staff understand this fully and exto the monitor when asked. Clier objective is also measurable, " will make a small prince more than one dollar from his funds given no more than 3 verb from staff on 6 consecutive oppopresented." Again there are task steps but in this case, the level of is measured: A needed hands on assistance R Verbal Reminder X Given opportunity did not proceed to gestural assistance. Independence In october, client #3 performed assistance. The QA consultant will meet with QMRP to review these program cited under W237 to insure that clearly stated in measurable term collection system and task analy the measurable objective and the clear protocols for staff to follow explain all of the above.	staff is the does not, explained it int #3's the does not, explained it int #3's the does not it is personal boal cues fortunities analyzed of assistance erform at the "A" s on ith the s and those they are ins, and data was reflect at there are	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	ILTIPLE CONSTRUCTION DING	(X3) DATE 5 COMPL	
		09G183	B. WING	i	400	I E /oco≖
MTS	PROVIDER OR SUPPLIER		2	STREET ADDRESS, CITY, STATE, ZIP CO 4414-16 JAY STREET, NE WASHINGTON, DC 20019		18/2007
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 231	Each written traini implement the objiction program plan must frequency of data to assess progress. This STANDARD Based on record mensure that each videsigned to impler individual program data necessary to desired objective frample, (Client #2). The finding includes 1. Review of Clien (IPP) and data collia approximately 12:00 objectives: a. Given Physical	nch level NDIVIDUAL PROGRAM PLAN In program designed to ectives in the individual and collection necessary to be able toward the desired objectives. Is not met as evidenced by evident training program ment the objectives in the plan (IPP) specified the type of assess progress toward the or one of the three clients in the	W 23	W237 See Responses for W231 above In addition, it must be recognize training objectives are sometim it is known that the person will independence for that objective such cases is to train the person maximum performance level whight be. Licensure itself has posuch training in the money man	ed that es run when not reach . The goal in to their hatever that ushed for	
	opportunities for 2 b. Given PA, the clin her clothes hamp opportunities for 2 cc. Given PA, the clithe hand washing p	consecutive months, lient will place her dirty clothes per with 50% of the consecutive months lient will complete all steps of		area and self medication and M with that philosophy. When the indicates "given Physical assista particular objectives it is becaus has recognized that the person v continually need that level of as can be trained to Accept that supcoorperate/participate fully. The being measured for such objecti is why the plus(+) or minus(-) to most appropriate.	QMRP ance" for se the IDT vill sistance but pport and at is what is ves and that	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

TATEMEN	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/GLIA (X2) MULTIPLE CONSTRUCTION A BUILDING		(X\$) DATË S COMPLI	URYEY ETED			
•		D9G183	B' MI		11		8/2007
NAME OF F	PROVIDER OR SUPPLIER			4414	T ADDRESS, CITY, STATE, ZIP C 416 JAY STREET, NE SHINGTON, DC 20019	CODE	·
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W 237	2. Rinse/wet hand 3. Put soap on ha 4. Lather hands w 5. Rinse hands 6. Pull paper towe 7. Dry hands 8. Turn of water According to the d a (+) if the client client did not complete to the did not assistance was be determined how the measured for programmed for programmed to the client's programmed programmed to the client's programmed to the client will verbal/physical programmed to the client will given verbal/physical participate turns 2 times a weak for the client will given verbal/physical participate turns 2 times a weak for the client will given verbal/physical participate turns 2 times a weak for the client will given verbal/physical participate turns 2 times a weak for the client will given verbal/physical participate turns 2 times a weak for the client will given verbal/physical participate turns 2 times a weak for the client will given verbal/physical participate turns 2 times a weak for the client will given verbal/physical participate turns 2 times a weak for the client will give a weak for the client	nds nds nith soap el off the roll ata sheets, staffs' documented completed the task and (-) if the collete the tasks or refused. The reflect at what level of eing used. It could not be nese goals were being gress. Interview with the Retardation Professional /07 at approximately 1:45 PM at the current data collection covide accurate measurement iss. nt #3's Individual Programs Plan llection on 10/17/07 at io PM revealed the following learn to count to sixty given compts at 70% accuracy 2 times secutive months. learn to tell time by the hour sical prompts at 60% accuracy		237			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES O(1) PROMOTERS UPPLIES (C) A

AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	LTIPLE CONSTRUCTION DING	(X3) DATE (
		09G183	B. WING		406	10/2007
NAME OF	PROVIDER OR SUPPLIER		3	TREET ADDRESS, CITY, STATE, ZIP COD 4414-16 JAY STREEY, NE WASHINGTON, DC 20019		18/2007
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX TAC	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	d Will brush his tee the day program with accuracy for 6 conse. Will make a smathan one \$1.00 dollars more than 3 vert. According to the data (+) if the client conclient did not complete data sheet did not reassistance was beind determined how the measured for progragualified Mental Ref (QMRP) on 10/18/01 acknowledged that the client's progress 483.440(f)(1)(i) PROCHANGE The individual prograficate by the qualified professional and revolutional to situs successfully complete identified in the individual prografication of	ath daily in the AM/PM and at the verbal prompts at 70% ecutive months. Ill purchase involving not more at of his personal funds given bal cues for six months. It sheets, staffs' documented inpleted the task and (-) if the ete the tasks or refused. The effect at what level of it gused. It could not be see goals were being ess. Interview with the tardation Professional at approximately 1:45 PM he current data collection de accurate measurement. INTERCEDITATION OF THE PROPERTY OF THE PROP	W 255			

PRINTED: 10/30/2007

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (XX) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING U9G183 10/18/2007 NAME OF PROVIDER OR SUPPLIER STREET AUDRESS, CITY, STATE, ZIP CODE 4414-16 JAY STREET, NE MTS WASHINGTON, DC 20019 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) W 255 Continued From page 19 W 255 The finding includes: W255 Client #2 achieved the cited objective in Review of the Client #2's Individual Program September of 2007. The QMRP Plans (IPP)s and related data collection was discontinued the program at that time. reviewed on 10/18/07 at approximately 8:44 AM. However, as is often done, the QMRP had There were no revisions made to the program staff collect data for another month that had been achieved at the stated criterion (October) to ensure that the skill level level as evidenced below: achieved was retained. It was. Data collection was totally discontinued as of Client #2's IPP indicated that the client will November 2007, Client #2 continues to tolerate ten (10) repetitions of shoulder/elbow perform the task as a structured activity. passive Range of Motion (ROM) on 80% of the trials recorded per month for 3 consecutive months. The documentation reflected that from June 2007 to September 2007, the client performed at tasks above 80%. Interviews with the Qualified Mental Retardation Professional (QMRP) on 10/18/07 at approximately 11:49 AM acknowledged that the client had achieved the objective according to the stated criterion. There was no document evidence that the QMRP discontinued the program after the criterion was met. W 283 483.440(f)(3)(ii) PROGRAM MONITORING & W 263 CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that each client's behavior intervention technique, including the use of behavior modification drugs was conducted with the written informed consent of

10/30/2007 04:09 FAX 2024429430

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED:	10/30/2007
FORM A	PPROVED
OMB NO.	039 <u>1</u>

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		09G183	B. WING		10/18	3/2007
NAME OF P	ROVIDER OR SUPPLIER	 	44	EET ADDRESS, CITY, STATE, ZIP CODE 14-16 JAY STREET. NE ASHINGTON, DC 20019		·
(X4) IU PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD RE	(XA) COMPLETION DATE
W 263	Continued From pa		W 263			
	the client, parents guardian for two of (Client #2 and Clie	(if the client is a minor) or legal two clients in the sample of #3).				
	The findings includ	le:				
W 331	written consent ha and Client #3's Be and for the use of medications. Interpretation Profes 2007 at approxima Client #2 and #3 do consents signed by recognized individ 483.460(c) NURS. The facility must previous in according to the profession of	ing services provide clients with nursing lance with their needs. is not met as evidenced by: ation, interviews, and record failed to ensure that nursing	W 331	W263 See Responses for W124		
	services were pro needs for one of f #2).	vided in accordance with clients our clients in the sample (Client				
	The finding includ					
	Client #2's Seizur	ing staff failed to ensure that e Activity Summary Log was thly as evidenced below:				
	10/16/07 at appro	ation administration observed on eximately 7:55 AM, Client #2 was entin (Chewable) 50 mg and for selzures. Review of the				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDERUŞUPPLIERICI,IA IDENTIFICATION NUMBER;	1 .	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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M T 5	OVIDER OR SUPPLIER		4	REET ADDRESS, CITY, STATE, ZIP 414-16 JAY STREET, NE VASHINGTON, DC 20019			
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W 436	approximately 8:50 had a diagnosis of review of the Clier "Seizure Activity Selzure Activity Selzure activity sur (0) seizures for the August 2007. Reviews Managen Retardation on the 3:37 PM revealed 7/12/07 that last for while sleeping. In Practical Nurse (Liapproximately 1:50 has seizures and the the seizure forms and documented as included as included as included as included as included as a seizure Activity Sur was no evidence the documented as included	o Orders on 10/17/07 at 0 AM revealed that the client of Seizure Disorder. Further of #2's medical book revealed a summary Log". According to the rumary log, Client #2 had zero or months of July 2007 and view of the nursing notes and ment for persons with Mental as same day at approximately that Client #2 had a seizure on or two minutes and 8/16/07 terview with the Licensed PN) on 10/18/07 at 0 PM revealed that Client #2 that the direct care staff fills out Further interview with the LPN nurses's review the seizure entitle seizure activity in the ammary Log monthly. There hat the seizure activity in the lammary Log monthly. There hat the seizure were being dicated by the LPN. ACE AND EQUIPMENT	W 436	W331 The Facility Manager purge 2007 and July 2007 logs wit the QMRP. The QMRP has formally. 11-7-07 The August and July logs wireconstructed using the nurs staff progress notes to ensure is full and complete.	hout consulting followed up ill be ing notes and		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUİLDIN	IPLE CONSTRUCTION	(X3) DATF SURVEY COMPLETED	
		09G183	B. WING_		10/1	18/2007
M T S	PROVIDER OR SUPPLIER		4	REET ADDRESS, CITY, SYATE, ZIP CODE 1414-16 JAY STREET, NE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST RE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CURR (EACH CORRECTIVE ACTION 3) CROSS-REPERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
W 436	Continued From pa	ge 22	W 436			
	The finding include:	5:				
	provided the necession evidenced below: 1a. Observations of and group home on used a basic wheeld alignment of the commender	to ensure that Client #3 was sary adaptive equipment as onducted at the day program 10/16/07 revealed Client #3 chair for mobility. Review of al Support Plan (ISP) dated at approximately 1:50 PM. Therapist Assessment (PT) ording to the PT assessment, at that Client #3 receive a new Motded Wheelchair!, wellity's Registered Nurse (RN) eximately 2:00 PM revealed put in several requests for the elichair back in February 2007, 2007, and July 2007. The RN to the facility had purchased a air in June 2007 to prevent a discharged from his day see of the survey, there was no ient had received custom as recommended as elish.		W436 JA. MTS has submitted all of the paperwork for client #3's custom wheelchair once again(October 2 Essential Rehab was to come out measure client #3 on October 29, did not. The RN and QMRP are prescheduled date but will submit information to an alternative vene processing if this is not resolved 107.	molded 2007). and 2007 but oursuing a the	
ı	(ISP) dated 8/20/07 1:50 PM revealed a dated 1/9/07. The M elbow comfy splint fi with the QMRP on 1 11:49 AM revealed (recommendations for The QMRP further r	#3's Individual Support Plan on 10/17/07 at approximately Mobility Evaluation (ME) It recommended a wrist and or contractures. Interview 0/18/07 at approximately that she was not aware of the or the adaptive equipment, evealed that the wrist and and not been purchased. At		B. Client #3's splint has been ord should be received by 11-15-07. The QMRP will ensure that adapt equipment needs are indicated or nursing Health Management Caras to track follow-up effectively, responses for W159 (item#7).	tive i the e Plans so	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION UNG	(X3) DATE SUF COMPLET	
		09G183	B. WING		10/18	/200 7
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATC, ZIP CODE 4414-16 JAY STREET, NE WASHINGTON, DC 20019	10710	72.001
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FIJLL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 436	the time of the survine client had receivadaptive equipment. 2. The facility failed wheelchair was in gibelow: On October 16, 200 the right armrest on observed to be torn 483.480(a)(1) FOO SERVICES Each client must rewell-balanced diet in specially-prescribed. This STANDARD is Based on observation review, the facility failets addressed the	ey, there was no evidence that yed the recommended to the recommended to ensure that Client #1's good repair was as evidenced of at approximately 7:00 AM , Client #1's wheelchair was in several places. D AND NUTRITION decive a nourishing, including modified and	W 460	2. The armrest of client #1's whee be replaced by 11-30-07. The QM RN separately will Audit adaptive equipment monthly to ensure all is adequate supply and in good repair 07.	RP and	
	at approximately 4:0 facility's main entree tomatoes sauce. Int Manager on Octobe 1:00 PM revealed the main entree of groun on October 16, 2007. Physician's (PCP) of October 17, 2007 at revealed that Client	bbserved on October 16, 2007 Do PM revealed that the ewas ground turkey with erview with the House of 17, 2007 at approximately lat Client # 3 was served the not turkey with tornato sauce of Review of the Primary Care of the dated February 2007 on approximately 1:25 PM #3 was allergic to tornatoes of products. Review of the		W460 The nutritionist will retrain staff of and diet restrictions of all of the in supported by 11-20-07. The QMI facility manager will observe meal minimum one weelky(QMRP0 or weekly (Facility manager) to ensur compliance. 11-15-07 In addition, the nutritionist will suppose substitutions for all excluded foods/drinks by 11-15-07.	dividuals RP and Is at twice re routine	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (UPN'1) PROVIDER/SUPPLIER/CLIA (UPN'1) PROVIDER/SUPPLIER/CLIA (UPN'1) PROVIDER/SUPPLIER/CLIA (UPN'1) PROVIDER/SUPPLIER/CLIA (UPN'1) PROVIDER/S			(X2) MULTIPL A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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W 460	facility's menu bod approximately 1:30 no substitute ment tomatoes or tomat the menu. In an ir Manager it was ac not have substitute was no evidence ti	age 24 Ik on October 18, 2007 at 2007	e were en ere on lity did here ed the	W 460			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIED/CLIA IDENTIFICATION NUMBER:		A BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/18/2007			
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NAME OF P	ROMDER OR SUPPLIER						
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
1 000	INITIAL COMMEN	TS		1 000			
	16, 2007 thru Octo initiated using the tax sample of three cli resident population with various disability added for a focuse The findings of the observations, interpretation and at two day pro-	was conducted from the 18, 2007. The survey process, and ents was selected from the four females and littles. A fourth cliented review in healthcate survey were based wiews with staff in the ograms, as well as a strative records, included	urvey was A random om a l one male was re———. on e home review of				
1 057	3502.15 MEAL SE	RVICE / DINING AR	EA\$	1 057			
	provide a variety of	itten on a weekly bas if foods at each meal to week and adjusted i.	, and be				
	Rased on observa review, the facility diets addressed the the four residents	t met as evidenced b tion, interview, and re failed to ensure them the nutritional needs of in the sample, (Resid	ecord apeutic of one of				
	2007 at approximate facility's main entranders sauce. I Manager on Octol 1:00 PM revealed the main entrea of sauce on October Primary Care Phy February 2007 on	es: n observed on Octobetely 4:00 PM revealete was ground turketer with the Hober 17, 2007 at approtent Resident # 3 was figurand turkey with 16, 2007. Review of sician's (PCP) orders October 17, 2007 at	ed that the y with use oximately as served tomato oxidated		W460 The nutritionist will retrain st and diet restrictions of all of t supported by 11-20-07. The facility manager will observe minimum one weelky(QMRF weekly (Facility manager) to compliance. 11-15-07 In addition, the nutritionist w menu substitutions for all exc foods/drinks by 11-15-07.	he individuals QMRP and meals at 0 or twice ensure routine	
Health Reg	ulation Administration				TITLE		(XII) DATE

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STATEMEN AND PLAN	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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NAME OF F	ROVIDER OR SUPPLIER		STREET AD	ADDRESS, CITY, STATE ZIP CODE				
MTS			4414-16 J	JAY STREET, NE IGTON, DC 20019				
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1 057	Continued From page 1			1057	-			
	#3 was allergic to to products. Review of October 18, 2007 at revoaled that there the staff to use who based products who interview with the Hiacknowledged that is substitute menus fo	PM revealed that Reparatoes and tomatoes the facility's menu by tapproximately 1:30 were no substitute menutors on the menu. In souse Manager it was the facility did not had resident # 3. There utritionist provided thous for Resident # 3.	es based pook on PM enus for poes an ve					
1 080	3502.18 MEAL SER Perishable foods sh temperatures in orde	RVICE / DINING ARE all be stored at prope or to conserve nutriti	er	1 060				
	Based on observation facility failed to ensur	met as evidenced by: on and staff interview are that the primary cility was operating a	the		3502.18			
		ire level was found r	tores		A thermometer was purchased for the food) refrigerator on 10-19-07. The manager will check for it routinely aweekly environmental audits.	facility		
1 090	3504.1 HOUSEKEEI	PING		1 090				
	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors.							

	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		R/CLIA MBER:	(X2) MULT A. BUILDIN B. WING	IPLE CONSTRUCTION	(X3) DATE S COMPLE	
NAME OF F	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE	1 10/1	0/200/
MTS			4414-16 J	IAY STREE STON, DC 2	I, NE		
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1 090	Based on observati GHMRP failed to m safe,clean,orderly a The findings include	met as evidenced by on and staff interviev aintain the facility in and sanitary manner.	v, the	1 090			
	Internal						
	1. Door knobs miss	sing off of Client #2's	closet				<u> </u>
	 Door knobs missing off of Client #2's closet Carpet throughout the facility appeared to be dirty and stained. The supply closet door was observed to be off the hinges and not secured. Client #3's recliner sofa chair (right arm) located in his bedroom appeared to have a hole in it exposing the cotton and wood. Interview the House Manager indicated that Client #2 would be getting a new recliner chair soon. Mold and Mildew was observed in the shower located on the first floor close to the kitchen. Shower located upstairs shower head was extended from the wall. There was clutter observed in the coat closet. (i.e. wheelchair and wheelchair accessories, hospital rail pad, etc.) 			3504.1 All of the repair/upkeep issue addressed 11-7-07. The facility manager will Aucenvironment weekly and reportantenance issues for follow 07	dit the physical		
	External						
		the back of the hous of debris and leaves.	se				

	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENT(FICATION NUMBER: 09G183			(X2) MULT A. BUILDII B. WING	NG	(X3) DATE SI COMPLE		
NAME OF	PROVIDER OR SUPPLIER	-	STREET AD	DRESS, CITY,	STATE, ZIP CODE	10/11	10/2007	
мтв				ay stree ston, dc 2				
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1 090	Continued From page 3			1 090				
I Ogs	 Paint chipping on the pole with the 4414 numbers located in front of the home. The wood framing outside of Client #1's and #2's window appeared to be rotten. The paint was observed to chipping. The paint appeared to be chipping around the side door. The wood framing appeared to be rotting. The wooden fence around the home had many large holes in them. Part of the fence that was to be attached to the home was detached and leaning into the backyard. The backside of the house appeared to have dirt built-up and debris. 		1 095	External 1. Gutters were cleaned 10-18-07 2. Pole will be repaired by 11-20-07 3. Window (client #1 and #2 bedroom) will be replaced by 11-30-07. 4. The side door will be repalced by 11-30-07 5. The fence will be replaced by 11-30-07 6. The dirt/debris at the backside of the house was cleaned out 10-18-07.				
		iustic agent shall be s d shall be out of di r e					· .	
	This Statute is not met as evidenced by: Based on observation the GHMRP failed to lock caustic agents being stored. The finding includes: During the environmental walk-through on 10/18/07 revealed that caustic agents were being stored in the bathroom under the sinks unlocked upstairs on the third level. (i.e. Scrub bubbles and Lysol Spray)				3504.6 The cited items were relocated to a locabinet. 10-18-07 Staff will be retrained to ensure that sitems are routinely stored in the locke cabinet after use. 11-30-07 The facility Manager will Audit computing routine weekly environmental 11-15-07	such ed		

	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;		A. BUILOII	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
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1 203	Continued From pa	ge 4		1 203	Andrew VIII I				
1 203	3509.3 PERSONNE	EL POLICIES		1203					
	Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter. This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have on file for review current job descriptions for all employees annually. The finding includes: Review of the personnel files conducted on October 17, 2007 at 2:20 PM, revealed that GHMRP failed to provide evidence of current signed job descriptions for ten direct care staff. [Staff #1, #2, #3, #4, #5, #6, #7, #8, #9 and #10].				3509.3 All staff will have received and sig updated job descriptions by 11-16-MTS is systematically tracking the anniversary dates for this item so a ensure that staff sign new job description a routine, annual basis. 11-15-6	07. s to			
1 206	3509.6 PERSONNE	EL POLICIES		l 206					
	Fach employee, prior to employment and annually thereafter, shall provide a physician 's certification that a health inventory has been performed and that the employee 's health status would allow him or her to perform the required duties.								
	This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all staff had current health certificates on file. The finding includes: Review of personnel records on October 18,								
		el records on Octobe ely 9:25 AM revealed					<u> </u>		

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SO	
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1 206	Continuèd From page 5			1206			
	certificates for the I Psychologist, Occup Recreational Thera Therapist consultar no documented evi certificates for six of an interview with the 18, 2007 at approxi- acknowledged that	nce of current health Primary Care Physic pational Therapist, No pist, Pharmacist and alts. Further review re dence of current hea but of ten direct care or e House Manager or imately 12:10PM it wo the health certification the survey. (Staff #	utritionist, Physical evealed lith staff. In October as ons were		3509.6 All of the updated health certification obtained by 11-30-07. MTS was aware of this issue Via audits and had notified staff and professionals of their specific file deficiencies. Follow up is ongoin 07.	internal	
l 227	1 227 3510.5(d) STAFT TRAINING			1 227			<u> </u>
	Each training program shall include, but not be limited to, the following: (c) Infection control for staff and residents;						
	This Statute is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to effectively train staff to implement emergency measures for five of five residents in the facility. (Resident #1, #2, #3 and #4)						
	The findings include	e:	1				
	The QMRP failed to ensure that all staff had been effectively trained to implement emergency measures for five of five residents in the facility as evidenced by:						
	Interview with the House Manager on October 18, 2007 at approximately 10:00 AM revealed that all staff was not trained in CPR. Record review on October 18, 2007 at approximately 10:10 AM revealed that three out of ten staff did not have current CPR certifications. There was no						

STATEMEN AND PLAN	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED	
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1 227	Continued From pa	ge 6	· · · · ·	1227		_		
	documented evidence that all direct care staff liad CPR training and current CPR certifications. (Staff #2, #3 and #5)							
	2. The QMRP failed to ensure that all staff had been effectively trained to implement emergency measures for five of five residents in the facility as evidenced by:				All ten staff have current CP certification and training inc three cited, but MTS has not received the cards from the tagent. The training was done	luding the yet raming		
	In an interview with the House Manager on October 18, 2007 at approximately 10:05 AM acknowledged that all staff was not trained in First Aid. Record review on June 25, 2007 at approximately 10:15 AM revealed that three out of ten staff did not have current First Aid certifications. There was no documented				September 2007, MTS will of cards by 11-30-07. A signature sheet and agend attached as proof of the train	a are		
		ect care staff had Fir First Aid certification			,			
1 379	3519.10 EMERGEN	ICIES		1 379		•		
	each GHMRP shall Health, Health Facil unusual incident or interferes with a resarrangement, well be places the resident be made by telepho followed up by writter	norting requirement in notify the Department ities Division of any devent which substantident 's health, welfateing or in any other vat risk. Such notification within any other was notification within are or the noxt work of the substantial in the substantial	nt of other dially are, living way tion shall shall be					
	This Statute is not met as evidenced by: Based on interview and record review, report incidents that pose a risk to client health or safety to governmental agencies, as required by DC regulation (22 DCMR Chapter 35 Section			·				

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A DUILDIN		(X3) DATE SURVEY COMPLETED			
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379	Continued From page 7 3519.10). The findings include: 1. Review of an unusual incident report dated 3/21/07 on 10/16/07 at approximately 9:05 AM revealed that Resident #2 had a seizure while sitting in her wheelchair at the day program. Further review of the incident revealed the client dropped her head an injured her right eyebrow and was taken to the emergency room. The client was diagnosed with an abrasion to the eyelid and contusion to the right eye. There was no documented evidence that this incident had been reported to governmental agencies as required. 2. Review of an unusual incident report dated February 5, 2007 on October 16, 2007 at approximately 9:05 AM revealed that Resident #1 was transported to the hospital emergency room for vomiting coffee ground material and was subsequently admitted for gastric intestinal bleeding. There was no evidence that this incident was reported to the DOH until February 12, 2007. 3. Review of an unusual incident report dated February 28, 2007 on October 16, 2007 at approximately 9:15 AM revealed that Resident #3 was transported to the hospital emergency room		1379	1. The day program involved doe routinely send incident reports or any other residential provide say their obligation is to send a reports to the DDS case manag will meet with the day program ensure that the program agrees such incident reports to the MT within 24 hours, so that it can be submitted to DOH and filed by that they send them to DOH and in addition to DDS case manage will involve DDS case manage ensure an agreement is reached. 2. The facility failed to send the irreport for client #1 to the IMC timely manner in this case. The will retrain all staff to ensure the understands that incident report be sent to the IMC by the end of shift on which the incident occur.	to MTS ers. They uch er. MTS to to send 'S home ne MTS or d MTS er MTS r to ncident in a e QMRP nat each its must				
	for evaluation of a superficial burn on the right side of his neck. There was no evidence that this incident was reported to the DOH until February 4, 2007.								
l 401	3520.3 PROFESSIONS	ON SERVICES: GEN	IERAL	l 401					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE IDENTIFICATION NO			A BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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1 401				I 401			
	Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure the provision of a recommended speech and language assessment for two of four residents in the sample. (Resident #1 and #4) The finding includes: 1. Breakfast observation on October 16, 2007 at						
!						·	
	approximately 6:40 AM, revealed that Resident # 1 was observed eating her food with a left handed curved built-up spoon at a fast pace. Staff verbally prompted the client to slow down and the client complied by slowing down her eating pace. Review of Resident #1's physicians's orders dated September 28, 2007 at approximately 11:45 AM on October 17, 2007 revealed that she has a diagnosis of spastic quadriplegia. Medical record review on October 17, 2007 at approximately 11:50 AM revealed that Resident #1 did not have a speech/ language assessment. In an interview with the Qualified Mental Retardation Professional (QMRP) on October 17, 2007 at 11:55 AM it was acknowledged that Resident #1 did not have a speech/ language assessment. There was no documented evidence that the client had been assessed by the speech/ language therapist. 2. Review of an undated investigative report on				1. Client #1 does have a s assessment that was file Assessment that was file "Speech Pathology" in (see attached copy)	ed under speech led under	
	October 16, 2007 a	dated investigative reat approximately 9:25 une 1, 2007, Residen	AM :				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:		(X2) MULTI 'A, BUILDIN B. WING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED					
	<u></u>	09G183				10/18/2007			
NAME OF P	ROVIDER OR SUPPLIER	`		NODREBB, CITY, STATE, ZIP CODE					
MTS				AY STREET TON, DC 2	0019	TION (CX)			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIALE DEFICIENCY)				
1401	Continued From pa	ige 9		1 401					
	admitted for right to discharged on June revealed a recomme be evaluated by the to rule out dysphas food, thin liquids are the QMRP on Octoracknowledged that speech/language awas no documented.	nospital emergency nower lobe pneumonial e 4, 2007. Further reviendation for Resider a speech/language is and associated as desalvia. In an intensider 17, 2007 at 3:55. Resident #4 did not assessment completed evidence that the other speech/language.	and view Int # 4 to therapist piration of dew with PM it was have a ed. There		2. Client #4 is scheduled to have swallowing study done on 11-1 Client #1 is also scheduled for swallow study on 11-09-07. The dysphasia issue will be address that time.	2-07. a			
1 422	3521.3 HABILITAT	TON AND TRAINING	à	1 422					
	and assistance to r	ll provide habilitation, residents in accordar ividual Habilitation Pl	ice with			1			
ı	This Statute is not met as evidenced by: Based on observation, staff interview and record review, the facility's Qualified Mental Retardation Professional (QMRP) failed to integrate, coordinate and monitor its clients active treatment programs.				·				
	The findings includ	le:		-	•				
	1. The QMRP failed to ensure that Resident #1 was provided a plate riser as recommended by the Occupational Therapist (OT) as evidenced by: Breakfast observation on October 16, 2007 at approximately 6:40 AM, revealed that the staff			Client #1's plate Riser will by 11-15-07. The QMRP wi checklist of the recommenda accepted by the team from e service and for each person s This checklist will be used to	Il develop a ations ach clinical supported.				
	placed three divide in order to elevate with direct care sta	ed plates on top of ea Resident #1's plate, aff on October 16, 20 AM, revealed that F	ach other Interview 07 at		recommendations and ensure properly implemented.				

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AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIE IDENTIFICATION NU 09G183		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		- COMPL	(X3) DATE SURVEY COMPLETED	
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
MTS				AY STREET STON, DC 20				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	' FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (X5) (ÉACH CÒRRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5)			
1422	#1 did not have a passessment dated 17, 2007 at approx Resident #1 was to modify her feeding overall independent of evidence that a recommended by the 2. The QMRP faller was provided adult recommended by the by: Evening observation approximately 4:45 assisted Resident assisted Resident assessment dated 2007 at approximaterials that mad the QMRP on Octon 1:20 PM it was acked did not have adult in the commended by the recommended by the recommended by the session of the passes and the commended by the recommended by the r	plate riser. Review of January 10, 2007 or Imately 1:15 PM, review of the provided a plate environment and indice in self feeding. To plate riser was provide OT. If to ensure that Residon he OT. If to ensure that Residon he Psychologist as ended that the psychologist as ended to provided adult he noise. In an interviolating with a control of the psychological June 10, 2007 on Outely 12:10PM, reveau the provided adult he noise. In an interviolating that no evidence that adult no evidence that adult no evidence that adult noise were provided and provided were pr	n October realed that riser to crease there was ided as ident #1 evidenced for at the staff child age ctober 17. led that obby ew with roximately ident #1 made alt hobby ed as	1 422	See Response for #7 abo In addition, the QMRP w adult hobby materials are as needed.	ill ensure that		
	for Resident #1 on		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
1 424		ATION AND TRAIN		1424				
	1	ll make modification: n at least every six (
		ly completed an obje d in the Individual Ha						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER IDENTIFICATION NUM			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
09G183			B. WING_	B. WING		8/2007		
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
MTS 4414-16.				JAY STREET, NE GTON, DC 20019				
(XA) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	TION SHOULD BE COMPLETE THE APPROPRIATE DATE			
1 424	Continued From pa	ige 11		1 424				
	Plan:							
	This Statute is not met as evidenced by: Based on record review, the Qualified Mental Retardation Professional (QMRP) failed to revise objectives identified in the individual program plans (IPPs)as they had been successfully achieved for one of four residents included the sample. (Resident #2) The finding includes: Review of the Resident #2's Individual Program Plans (IPP)s and related data collection was reviewed on 10/18/07 at approximately 8:44 AM. There were no revisions made to the program that had been achieved at the stated criterion level as evidenced below: Resident #2's IPP indicated that the client will tolerate ten (10) repetitions of shoulder/elbow passive Range of Motion (ROM) on 80% of the			Client #2 achieved the cited objections of 2007. The QMRP discontinued the program at that However, as is often done, the QU staff collect data for another mon (October) to ensure that the skill achieved was retained. It was. Da collection was totally discontinue				
	trials recorded per month for 3 consecutive months. The documentation reflected that from June 2007 to September 2007, the client performed at tasks above 80%.				November 2007, Client #2 continu perform the task as a structured ac	les to		
	Professional (QMR) approximately 11:49 resident had achieve the stated criterion.	9 AM acknowledged /ed the objective according There was no docu MRP discontinued to	that the ording to ment		<u>.</u>			
	The habilitation and	ATION AND TRAINI training of residents de, when appropriate llowing areas:	by the	l 443				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION NUM			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED		
09G1B3					10/18/2007		
NAME OF PROVIDER OR SUPPLIER STREET AD			DRESS, CITY.	STATE, ZIP CODE			
MTS			S JAY STREET, NE NGTON, DC 20019				
PREFIX (EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	ULD BE COMPLETE		
(m) Financial mana and banking); This Statute is not Based on staff inter Group Home for Me (GHMRP) failed to skill building of resident: The finding include: 1. Review of Resident: The finding include: 1. Review of Reside Plan (IPP) dated Oc 2007 at approximate following money manages are staff with the c. Pay for item e. Wait for the charter f. Say thank you Further review of the staff was instructed accomplished if all completed and (-) met or refused. In Mental Retardation October 18, 2007 a acknowledged that oriteria for mastery There was no evide criteria provided metal.	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 12 (m) Financial management (Including budgeting and banking); This Statute is not met as evidenced by: Based on staff interview and record review the Group Home for Mentally Retarded Person (GHMRP) failed to ensure the habilitation and skill building of residents as required by this section. (Resident #1 and #2) The finding includes: 1. Review of Resident #1's Individual Program Plan (IPP) dated October 2007, on October 17, 2007 at approximately 1:50 PM included the following money management objectives: a. Select an item b. Take item to the cashler c. Pay for item e. Wait for the change/receipt			The QMRP did not acknowledge money management objective for and #3 "had multiple criteria for mand was not measurable." To the othe QMRP does not agree client # measurable objective in the mone management area is, "wi small purchase in the community month for six months consecutive. That objective is measurable, Item through "f" referred to by the sur the functional steps that must be to successfully complete the task surveyor seems to be confusing "criteria for mastery" with task and breakdown. Plus (+) or (-) is used opposed to levels of assistance (P gestural, verbal, Independent) become QMRP and IDT recognizes that will always need physical assistant make a purchase, along with one staff support and guidance. The other aims to measure her level of participation and coorperation. Stinstructed to score plus(+) if she -Accepts assistance. Follows instructions -coorperates/participates fully. For each step and minus (-) if she staff understand this fully and exto the monitor when asked. Client objective is also measurable, "will make a small put no more than one dollar from his funds given no more than 3 verbiform staff on 6 consecutive oppon presented." Again there are task steps but in this case, the level of is measured:	client #1 mastery contrary, 1's y II make a once a omonths." ms "a" veyor are completed The multiple m		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE IDENTIFICATION NU.		MBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		COMPLE	(x3) DATE SURVEY COMPLETED 10/18/2007			
NAME OF PROVIDER OR SUPPLIER STR			4414-15 JA	REET ADDRESS, CITY, STATE, ZIP CODE 414-15 JAY STREET, NE ASHINGTON, DC 20019					
(X4) ID PREFIX TAG	/EACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORM	'FULL	ID PREFIX TAG	PROVIDER'S FLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE COMPLETE DATE DATE			
1 443	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		1443	A needed hands on assistance R Verbal Reminder X= Given opportunity did not G= gestural assistance I= Independence In october, client #3 performitevel for all steps. (Needed has assistance). The QA consultant will meet QMRP to review these progreited under W237 to insure the collection system and task at the measurable objective and clear protocols for staff to fo explain all of the above.	ed at the "A" unds on with the ams and those hat they are terms, and data halysis reflect				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUM		CLIA ER:	(X2) MULTIP A. BUILDING B. WING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/18/2007			
	<u> </u>	09G183		1	TATE, ZIP CODE	1 10/18	12007	
NAME OF P	ROVIDER OR SUPPLIER		4414-16 JA	Y STREET, TON, DC 20	NE			
(X4) ID PREFIX TAG	EUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CHOSS-REFERENCED TO THE APP DEFICIENCY)	TION SHOULD BE COMPLETE THE APPROPRIATE DATE		
R 000	falled to ensure the clearances on file. The finding include Review of ten persuporoxima	v and record review, the at all staff had police es: sonnel records on Octol ately 2:10 PM revealed once of a police clearance.	ber 18,	R 000	R000 Staff #2 has a police clearance. (see attached Copy) 11-1-07			
Health Reg	ulation Administration				TITLE		(X6) DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM